



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4799



Date

Institution

Coordinator/Faculty Personnel

- ☐ I request to PARTICIPATE in the following:
☐ I request to CANCEL the following:

Department of: _____

Clerkship/Subinternship: _____

USUHS Course No: _____

Requested Dates: _____

Block(s): _____

Student's Name, Graduation Year

Student's Address

Student's Signature

Student's SSAN/Service

Student's Phone Number

DO NOT WRITE BELOW THIS LINE/DO NOT DETACH

The following information is to be completed by the Coordinator/Faculty Personnel:

This confirms that _____ (student) has been scheduled/cancelled to participate in
_____ clerkship/subinternship during _____ (timeframe).

Signature (Coordinator/Faculty Personnel)

Phone Number/Fax Number

Date

USUHS FORM 1304 (6/96)

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